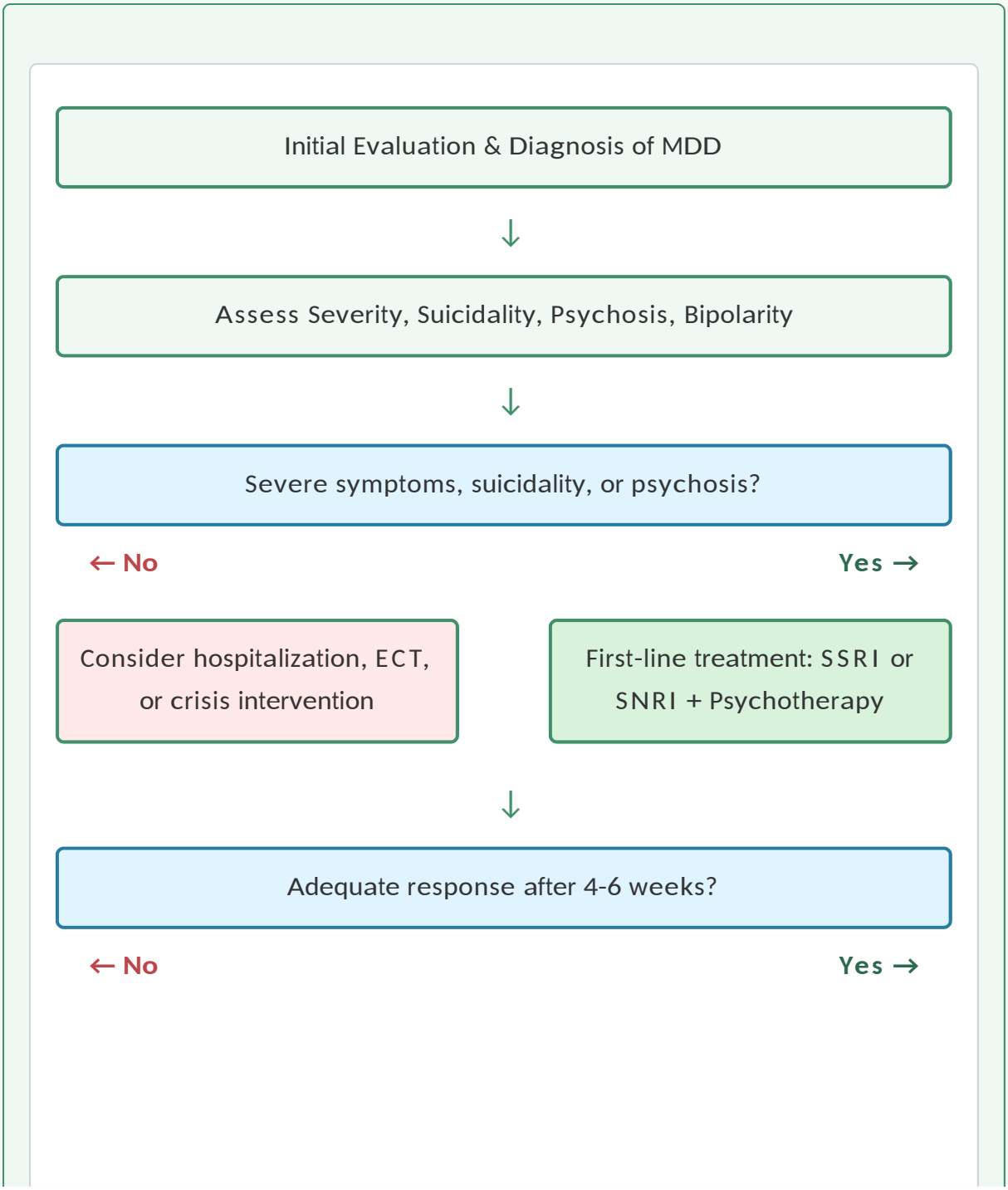
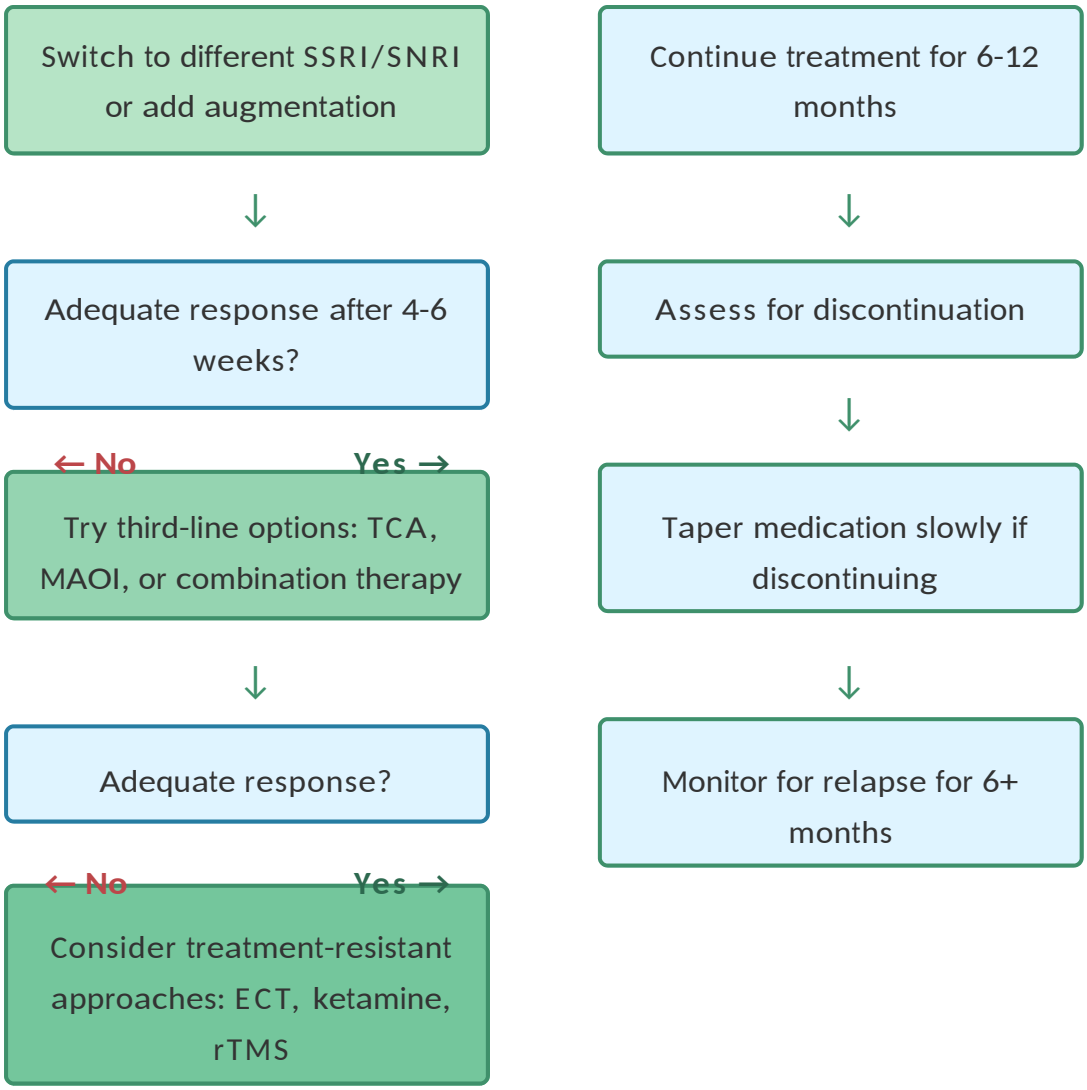
🧠 Evidence-Based Treatment Algorithms for Psychiatric Disorders

💊 Major Depressive Disorder (MDD) Treatment Algorithm





First-Line Treatment Options

SSRIs: Sertraline, Escitalopram, Fluoxetine, Citalopram

SNRIs: Venlafaxine, Duloxetine

Psychotherapy: Cognitive Behavioral Therapy (CBT), Interpersonal Therapy (IPT)

Second-Line Treatment Options

Switch to different SSRI/SNRI

Augmentation strategies:

- Add bupropion
- Add mirtazapine
- Add second-generation antipsychotic (aripiprazole, quetiapine, brexpiprazole)
- Add lithium
- Add thyroid hormone (T3)

Third-Line Treatment Options

Tricyclic Antidepressants (TCAs): Nortriptyline, Amitriptyline

Monoamine Oxidase Inhibitors (MAOIs): Phenelzine, Tranylcypromine

Combination therapy: SSRI + Mirtazapine, SSRI + TCA

Treatment-Resistant Depression Options

Electroconvulsive Therapy (ECT)

Ketamine/Esketamine

Repetitive Transcranial Magnetic Stimulation (rTMS)

Vagus Nerve Stimulation (VNS)

Deep Brain Stimulation (DBS)

Monitoring Requirements

Baseline: Complete blood count, comprehensive metabolic panel, thyroid function tests

Follow-up: Assess response at 2, 4, 6, 8, and 12 weeks

Ongoing: Monitor for suicidality, especially in adolescents and young adults

Specific monitoring:

- TCAs: ECG, blood levels

- Lithium: Lithium levels, renal and thyroid function
- Antipsychotics: Metabolic parameters, movement disorders

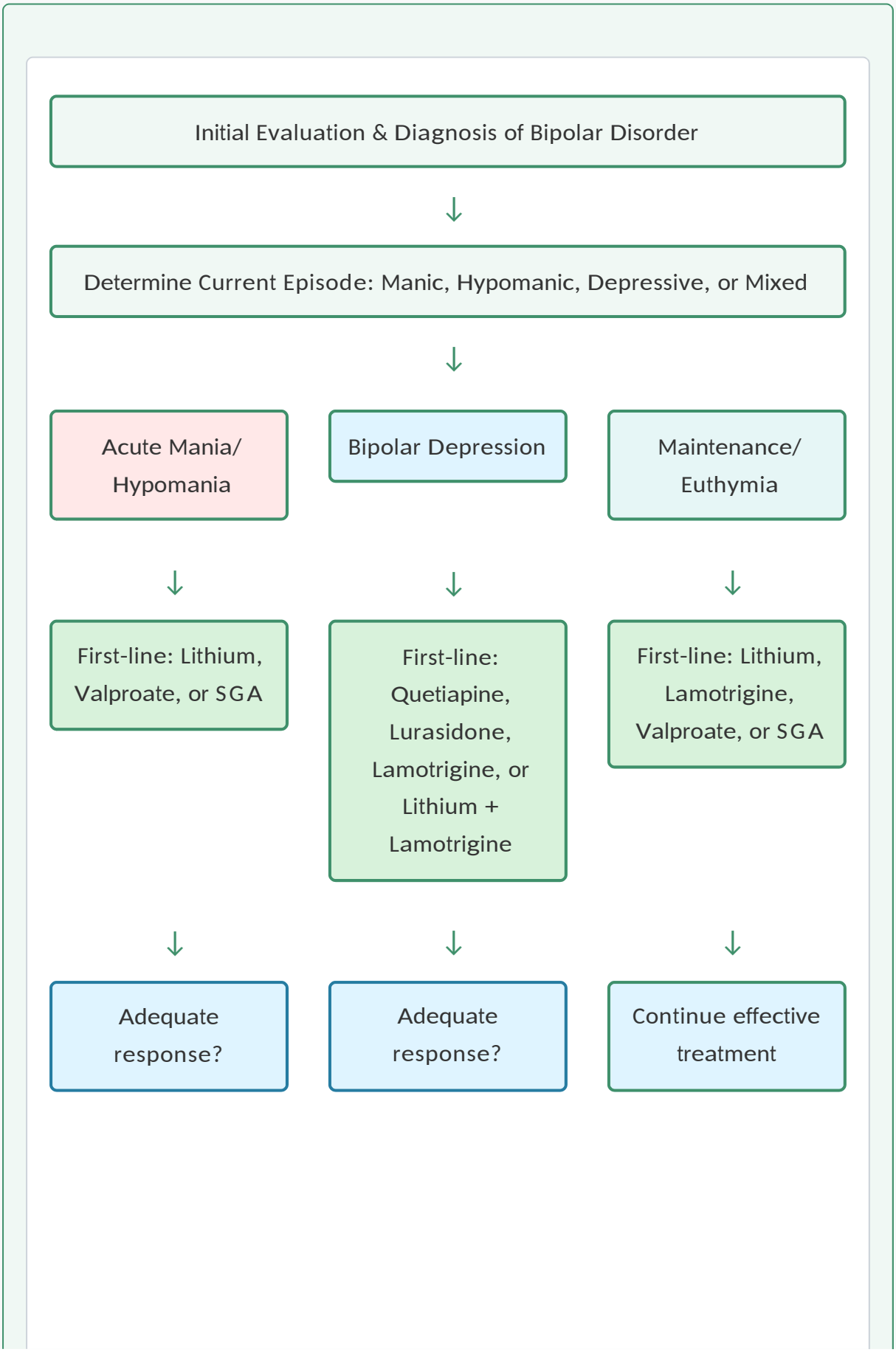
Medication Dosing Guidelines

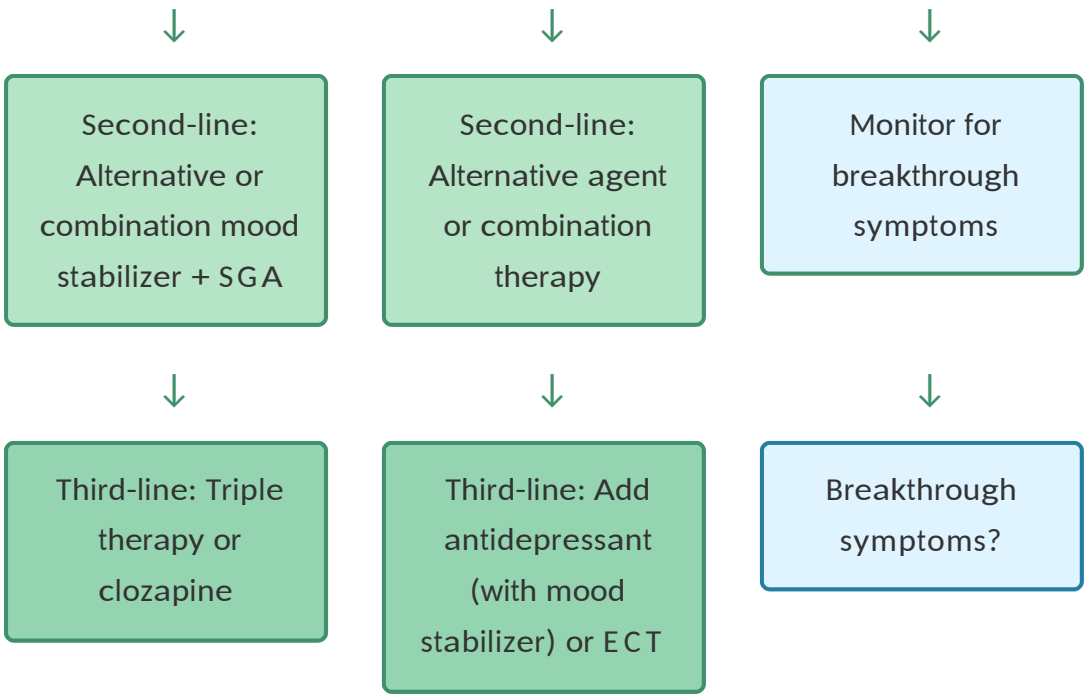
Medication	Starting Dose	Therapeutic Dose Range	Maximum Dose
Sertraline	25-50 mg/day	50-200 mg/day	200 mg/day
Escitalopram	5-10 mg/day	10-20 mg/day	20 mg/day
Fluoxetine	10-20 mg/day	20-60 mg/day	80 mg/day
Venlafaxine XR	37.5-75 mg/day	150-225 mg/day	375 mg/day
Duloxetine	30 mg/day	60-120 mg/day	120 mg/day
Bupropion XL	150 mg/day	300 mg/day	450 mg/day
Mirtazapine	15 mg/day	30-45 mg/day	45 mg/day
Aripiprazole (augmentation)	2-5 mg/day	5-15 mg/day	15 mg/day

Warning: Always assess for suicidality before and during treatment. Monitor closely during the first few weeks of treatment and with dose changes. Use caution when prescribing TCAs and MAOIs due to toxicity in overdose and dietary/drug interactions.

Clinical Pearl: *Antidepressant response may take 4-6 weeks for full effect. Partial response at 2-4 weeks often predicts eventual response. Consider psychotherapy in combination with medication for better outcomes, especially for mild to moderate depression.*

💊 Bipolar Disorder Treatment Algorithm





Acute Mania/Hypomania Treatment

First-line options:

- Lithium
- Valproate
- Second-generation antipsychotics (SGAs): Olanzapine, Risperidone, Quetiapine, Aripiprazole, Ziprasidone, Asenapine

Second-line options:

- Carbamazepine
- Lithium + SGA
- Valproate + SGA
- Lithium + Valproate

Third-line options:

- Triple therapy (Lithium + Valproate + SGA)
- Clozapine
- Electroconvulsive therapy (ECT)

Bipolar Depression Treatment

First-line options:

- Quetiapine
- Lurasidone (with lithium or valproate)
- Lamotrigine
- Lithium
- Olanzapine-fluoxetine combination

Second-line options:

- Valproate
- Lithium + Lamotrigine
- Adjunctive psychotherapy (CBT, family-focused, interpersonal)

Third-line options:

- Cariprazine
- Olanzapine
- Lithium or valproate + SSRI/bupropion (with careful monitoring)
- Electroconvulsive therapy (ECT)

Maintenance Treatment

First-line options:

- Lithium
- Lamotrigine (especially for depression prevention)
- Valproate
- Quetiapine
- Aripiprazole

Second-line options:

- Olanzapine
- Risperidone LAI

- Ziprasidone
- Carbamazepine

Warning: Antidepressant monotherapy is contraindicated in bipolar disorder due to risk of mood switch. Always use antidepressants with mood stabilizers if needed. Discontinue antidepressants after acute bipolar depression resolves.

Medication Dosing Guidelines

Medication	Starting Dose	Therapeutic Dose Range	Therapeutic Blood Level
Lithium	300 mg BID or TID	900-1800 mg/day	0.6-1.2 mEq/L (maintenance) 0.8-1.2 mEq/L (acute mania)
Valproate	250-500 mg BID	750-2500 mg/day	50-125 µg/mL
Lamotrigine	25 mg/day (titrate slowly)	100-400 mg/day	Not established
Carbamazepine	100-200 mg BID	600-1600 mg/day	4-12 µg/mL
Quetiapine	50 mg BID	300-800 mg/day	Not established
Olanzapine	5-10 mg/day	5-20 mg/day	Not established
Risperidone	1-2 mg/day	2-6 mg/day	Not established
Aripiprazole	5-15 mg/day	15-30 mg/day	Not established

Monitoring Requirements

Lithium:

- Baseline: CBC, electrolytes, BUN/Cr, TSH, ECG (>40 years)

- Lithium levels: 5-7 days after initiation/dose change, then every 3-6 months
- Renal and thyroid function: Every 6-12 months

Valproate:

- Baseline: LFTs, CBC with platelets, pregnancy test
- LFTs and CBC: After 1 month, then every 3-6 months
- Valproate levels: As clinically indicated

Carbamazepine:

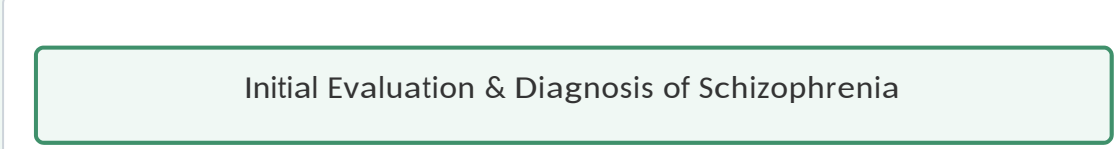
- Baseline: CBC, LFTs, electrolytes, pregnancy test
- CBC and LFTs: Monthly for first 3 months, then every 6-12 months
- Carbamazepine levels: As clinically indicated

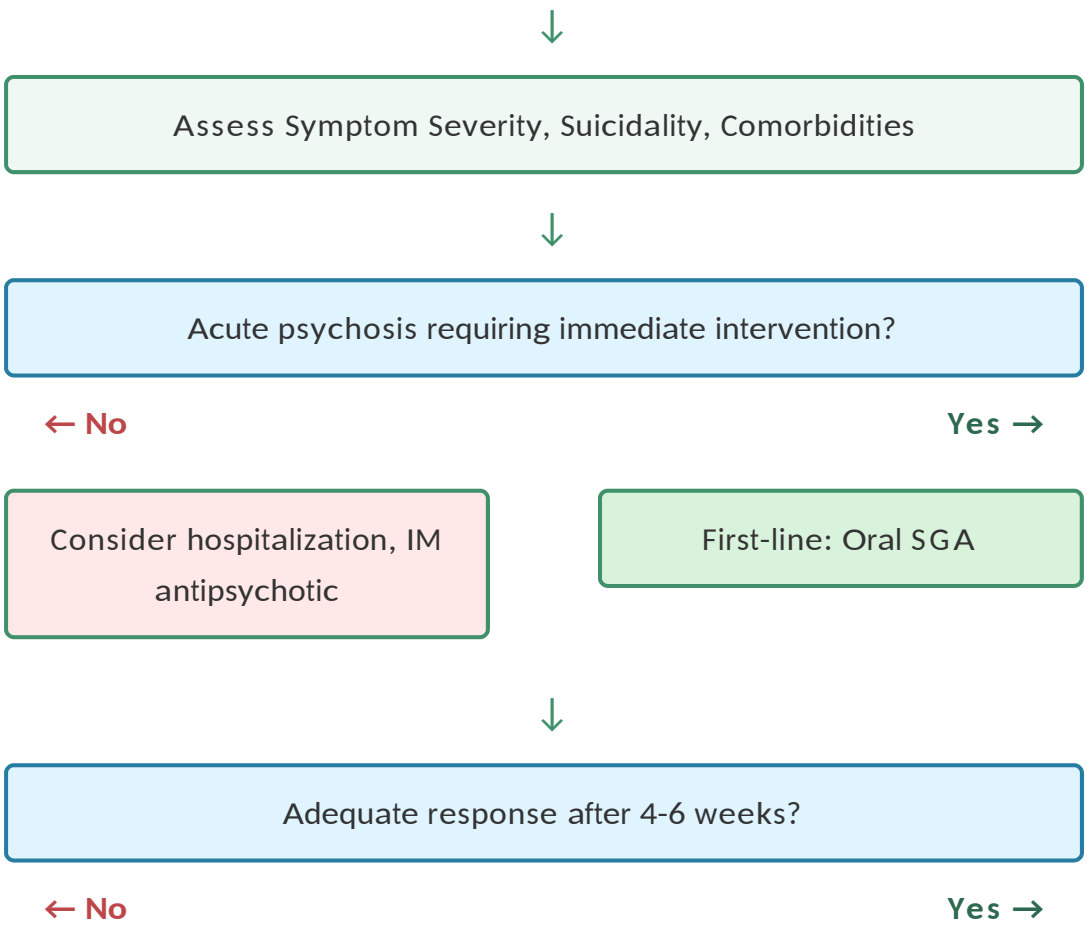
Antipsychotics:

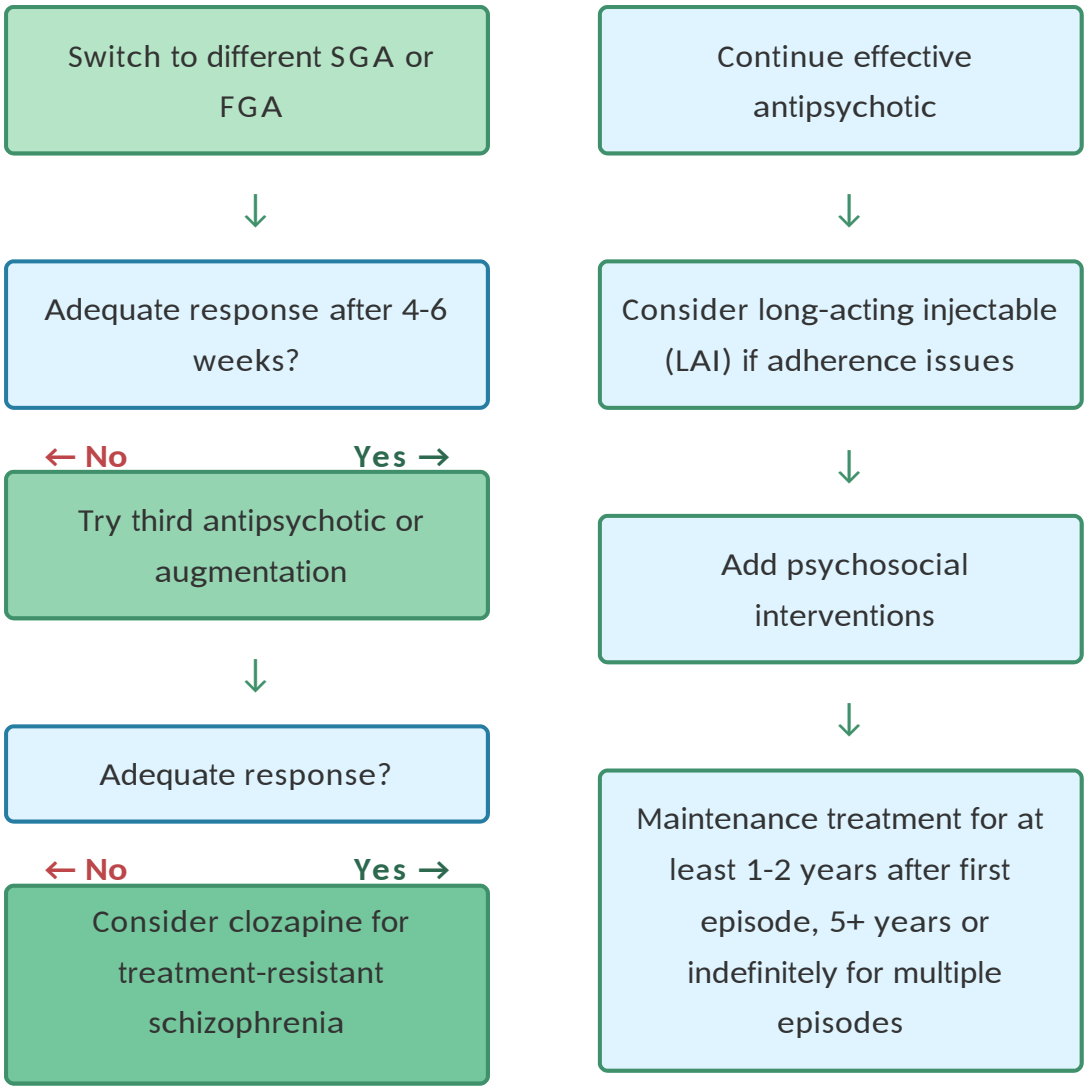
- Baseline: Weight, BMI, waist circumference, BP, fasting glucose, lipid panel
- Weight: Monthly for 3 months, then quarterly
- Metabolic parameters: At 3 months, then annually
- AIMS for EPS: Every 6 months

Clinical Pearl: *Lithium remains the gold standard for suicide prevention in bipolar disorder. Consider predominant polarity (manic vs. depressive) when selecting maintenance treatment. Lamotrigine is more effective for preventing depression, while lithium and antipsychotics are more effective for preventing mania.*

💊 Schizophrenia Treatment Algorithm




Assess Symptom Severity, Suicidality, Comorbidities
Acute psychosis requiring immediate intervention?
← No
Yes →
Consider hospitalization, IM antipsychotic
First-line: Oral SGA
Adequate response after 4-6 weeks?
← No
Yes →



First-Line Treatment Options

Second-Generation Antipsychotics (SGAs):

- Risperidone
- Olanzapine
- Quetiapine
- Ziprasidone
- Aripiprazole
- Paliperidone
- Lurasidone
- Brexpiprazole
- Cariprazine

Second-Line Treatment Options

First-Generation Antipsychotics (FGAs):

- Haloperidol
- Perphenazine
- Fluphenazine
- Loxapine

Alternative SGA not tried in first-line

Third-Line Treatment Options

Augmentation strategies:

- Antipsychotic + mood stabilizer (valproate, lithium)
- Combination of two antipsychotics
- Add lamotrigine (for negative symptoms)

Treatment-Resistant Schizophrenia Options

Clozapine (after failure of at least 2 adequate antipsychotic trials)

Clozapine augmentation:

- Add another antipsychotic
- Add mood stabilizer
- Add ECT (for catatonia or persistent positive symptoms)
- Add lamotrigine or glycine (for negative symptoms)

Long-Acting Injectable (LAI) Antipsychotics

Consider for:

- History of non-adherence
- Patient preference
- Multiple relapses

Options:

- Risperidone LAI (2 weeks)
- Paliperidone palmitate (1 month or 3 months)
- Aripiprazole monohydrate (1 month)
- Aripiprazole lauroxil (1-2 months)
- Olanzapine pamoate (2-4 weeks)
- Haloperidol decanoate (4 weeks)
- Fluphenazine decanoate (2-4 weeks)

Medication Dosing Guidelines

Medication	Starting Dose	Therapeutic Dose Range	Maximum Dose
Risperidone	1-2 mg/day	2-6 mg/day	16 mg/day
Olanzapine	5-10 mg/day	10-20 mg/day	30 mg/day
Quetiapine	25-50 mg BID	300-750 mg/day	800 mg/day
Aripiprazole	5-10 mg/day	10-30 mg/day	30 mg/day
Ziprasidone	20 mg BID	40-80 mg BID	160 mg/day
Paliperidone	3-6 mg/day	3-12 mg/day	12 mg/day
Lurasidone	40 mg/day	40-80 mg/day	160 mg/day
Haloperidol	1-2 mg BID	5-20 mg/day	30 mg/day
Clozapine	12.5-25 mg/day	300-450 mg/day	900 mg/day

Monitoring Requirements

All antipsychotics:

- Baseline: Weight, BMI, waist circumference, BP, fasting glucose, lipid panel, ECG (if cardiac risk)
- Weight: Monthly for 3 months, then quarterly
- Metabolic parameters: At 3 months, then annually
- AIMS for EPS: Every 6 months

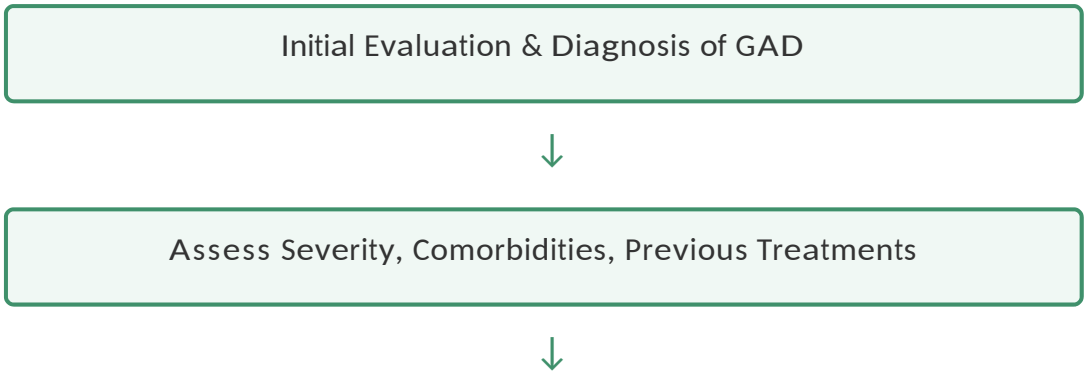
Clozapine-specific monitoring:

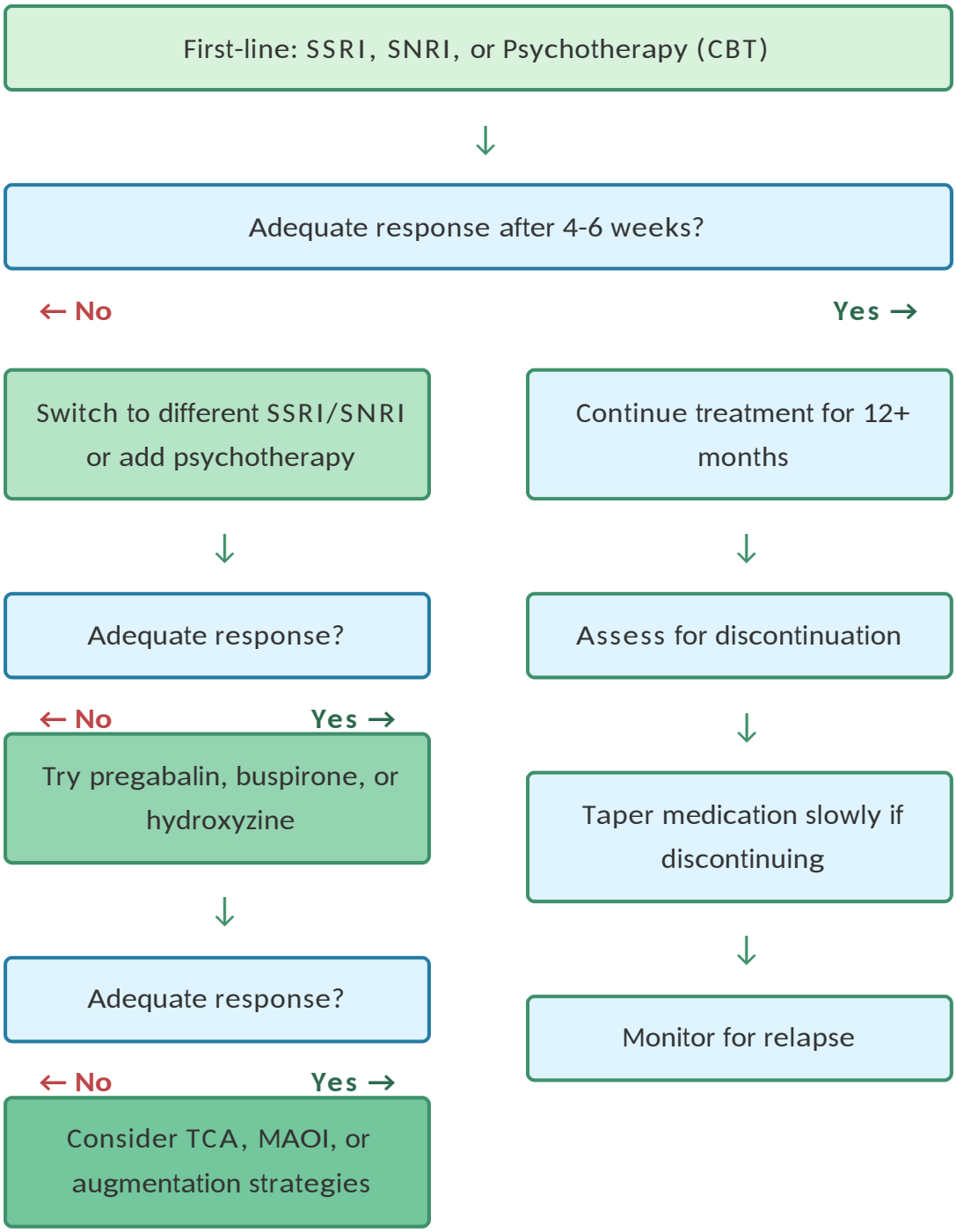
- ANC weekly for 6 months, then every 2 weeks for 6 months, then monthly
- Myocarditis monitoring: ECG and troponin at baseline and weekly for first month
- Consider clozapine levels if response inadequate or toxicity suspected

Warning: Clozapine requires registration in a monitoring program due to risk of agranulocytosis. Olanzapine pamoate can cause post-injection delirium/sedation syndrome requiring 3-hour observation. Antipsychotics increase mortality in elderly patients with dementia-related psychosis.

Clinical Pearl: *Negative symptoms and cognitive impairment often respond poorly to antipsychotics. Consider psychosocial interventions (cognitive remediation, social skills training) for these domains. SGAs may have advantages for negative symptoms compared to FGAs, but the difference is modest.*

💊 Generalized Anxiety Disorder (GAD) Treatment Algorithm





First-Line Treatment Options

SSRIs:

- Escitalopram
- Paroxetine
- Sertraline

SNRIs:

- Venlafaxine XR
- Duloxetine

Psychotherapy:

- Cognitive Behavioral Therapy (CBT)
- Acceptance and Commitment Therapy (ACT)

Second-Line Treatment Options

Alternative SSRI/SNRI not tried in first-line

Pregabalin

Buspirone

Third-Line Treatment Options

Hydroxyzine

Tricyclic Antidepressants (TCAs):

- Imipramine
- Amitriptyline

Quetiapine (low dose)

Fourth-Line/Treatment-Resistant Options

Monoamine Oxidase Inhibitors (MAOIs):

- Phenelzine

Augmentation strategies:

- Add pregabalin to SSRI/SNRI
- Add low-dose antipsychotic
- Add buspirone to SSRI/SNRI

Short-term Adjunctive Treatment

Benzodiazepines (short-term use only, 2-4 weeks):

- **Alprazolam**
- **Clonazepam**
- **Diazepam**
- **Lorazepam**

Warning: Risk of dependence, tolerance, withdrawal, cognitive impairment. Not recommended for long-term use or in patients with history of substance use disorders.

Medication Dosing Guidelines

Medication	Starting Dose	Therapeutic Dose Range	Maximum Dose
Escitalopram	5-10 mg/day	10-20 mg/day	20 mg/day
Paroxetine	10-20 mg/day	20-50 mg/day	60 mg/day
Sertraline	25-50 mg/day	50-200 mg/day	200 mg/day
Venlafaxine XR	37.5-75 mg/day	75-225 mg/day	225 mg/day
Duloxetine	30 mg/day	60-120 mg/day	120 mg/day
Pregabalin	75 mg BID	300-600 mg/day	600 mg/day
Buspirone	5 mg BID	15-30 mg/day	60 mg/day
Hydroxyzine	25 mg TID-QID	50-100 mg TID-QID	400 mg/day

Monitoring Requirements

SSRIs/SNRIs:

- Assess for response and side effects at 2, 4, 8, and 12 weeks

- Monitor for activation, suicidality (especially in young adults)
- Check BP with SNRIs, especially venlafaxine

Pregabalin:

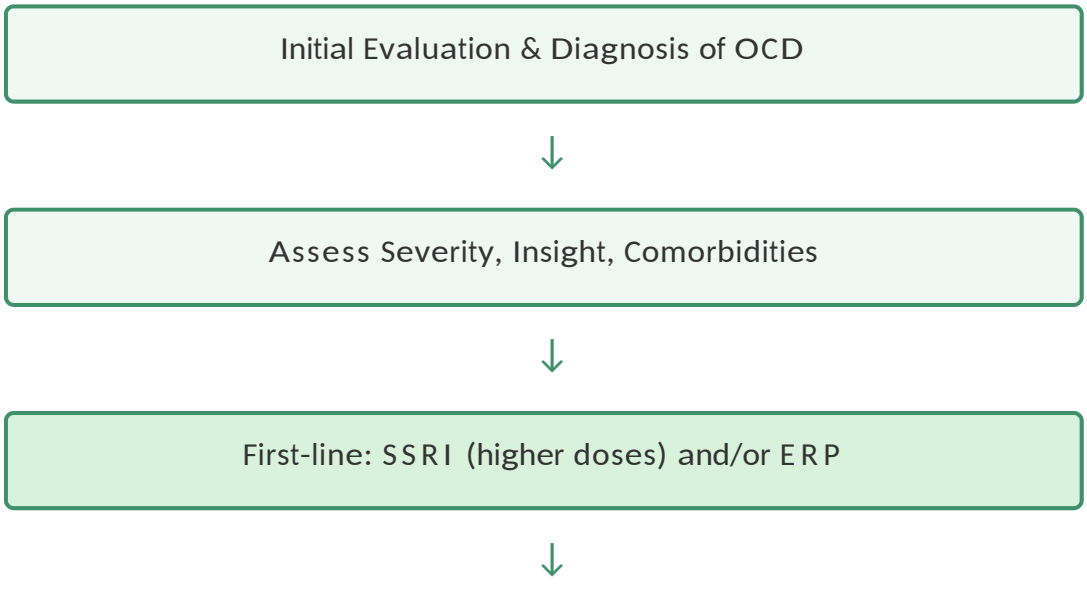
- Monitor for sedation, dizziness, weight gain
- Adjust dose in renal impairment

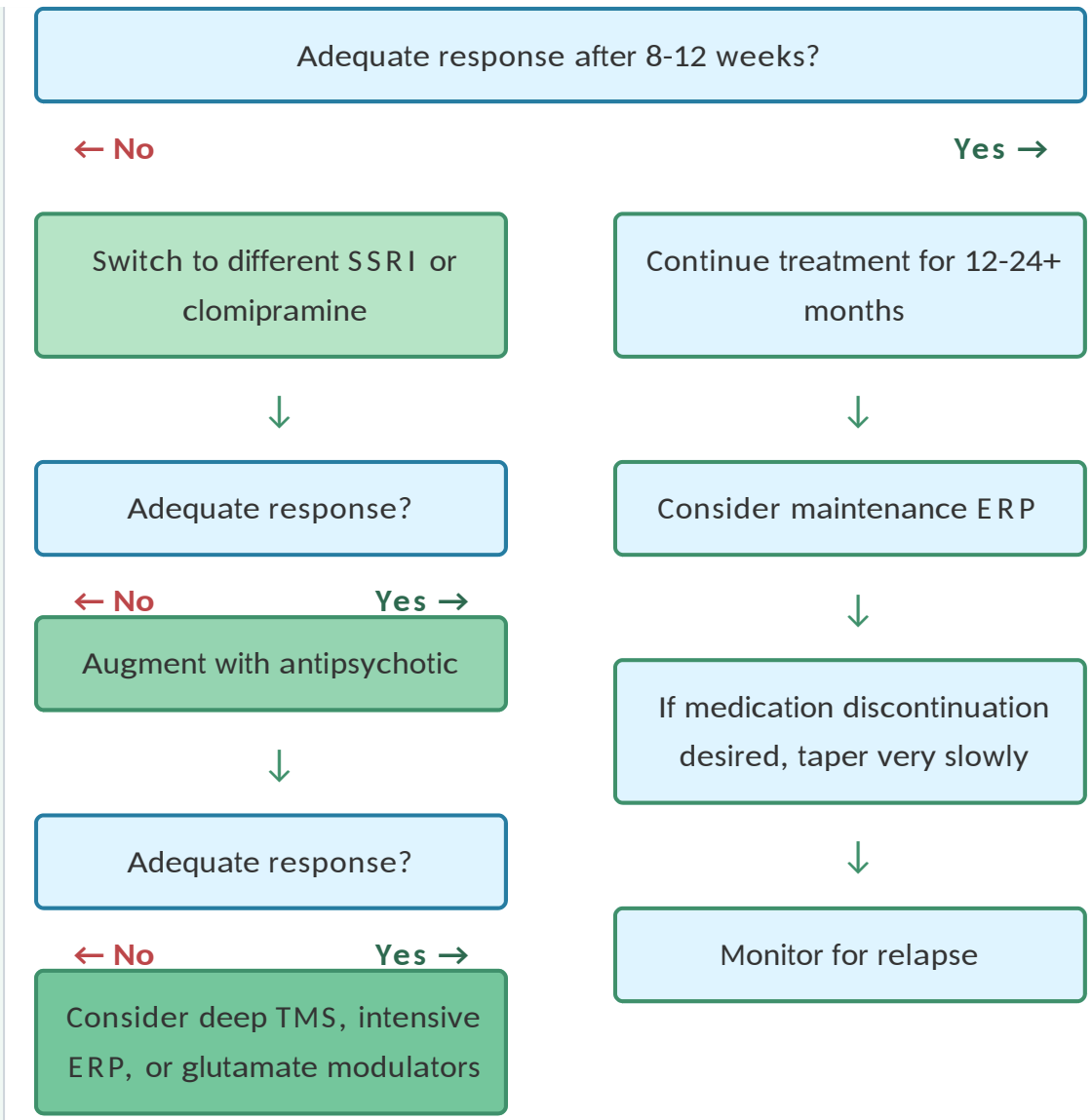
Benzodiazepines:

- Assess for sedation, cognitive impairment, dependence
- Limit duration of use
- Plan for gradual taper when discontinuing

Clinical Pearl: *Response to pharmacotherapy for GAD may take 4-6 weeks for full effect. Combining medication with CBT often produces better outcomes than either treatment alone. Pregabalin has faster onset of action (1-2 weeks) compared to SSRIs/SNRIs.*

💊 Obsessive-Compulsive Disorder (OCD) Treatment Algorithm





First-Line Treatment Options

SSRIs (higher doses than for depression):

- Fluoxetine
- Sertraline
- Paroxetine
- Fluvoxamine
- Escitalopram

Psychotherapy:

- Exposure and Response Prevention (ERP)

Second-Line Treatment Options

Alternative SSRI not tried in first-line

Clomipramine (TCA with strong serotonergic effects)

Third-Line/Augmentation Strategies

Antipsychotic augmentation:

- Risperidone
- Aripiprazole
- Quetiapine
- Olanzapine

Other augmentation strategies:

- Add clomipramine to SSRI (with caution)
- Add another SSRI (with caution)

Treatment-Resistant OCD Options

Glutamate modulators:

- Memantine
- N-acetylcysteine
- Riluzole

Other options:

- Deep Transcranial Magnetic Stimulation (dTMS)
- Intensive residential treatment with ERP
- Gamma knife capsulotomy
- Deep brain stimulation

Medication Dosing Guidelines

Medication	Starting Dose	Therapeutic Dose Range for OCD	Maximum Dose

Fluoxetine	20 mg/day	40-80 mg/day	120 mg/day
Sertraline	50 mg/day	100-200 mg/day	400 mg/day
Paroxetine	20 mg/day	40-60 mg/day	80 mg/day
Fluvoxamine	50 mg/day	200-300 mg/day	400 mg/day
Escitalopram	10 mg/day	20-40 mg/day	40 mg/day
Clomipramine	25 mg/day	150-250 mg/day	300 mg/day
Risperidone (augmentation)	0.5 mg/day	1-3 mg/day	4 mg/day
Aripiprazole (augmentation)	2.5 mg/day	5-15 mg/day	15 mg/day

Monitoring Requirements

SSRIs:

- Assess for response and side effects at 4, 8, and 12 weeks
- OCD often requires higher doses and longer trial duration (10-12 weeks)

Clomipramine:

- Baseline: ECG (QTc interval)
- Follow-up ECG with dose increases
- Consider blood levels if response inadequate or toxicity suspected

Antipsychotics:

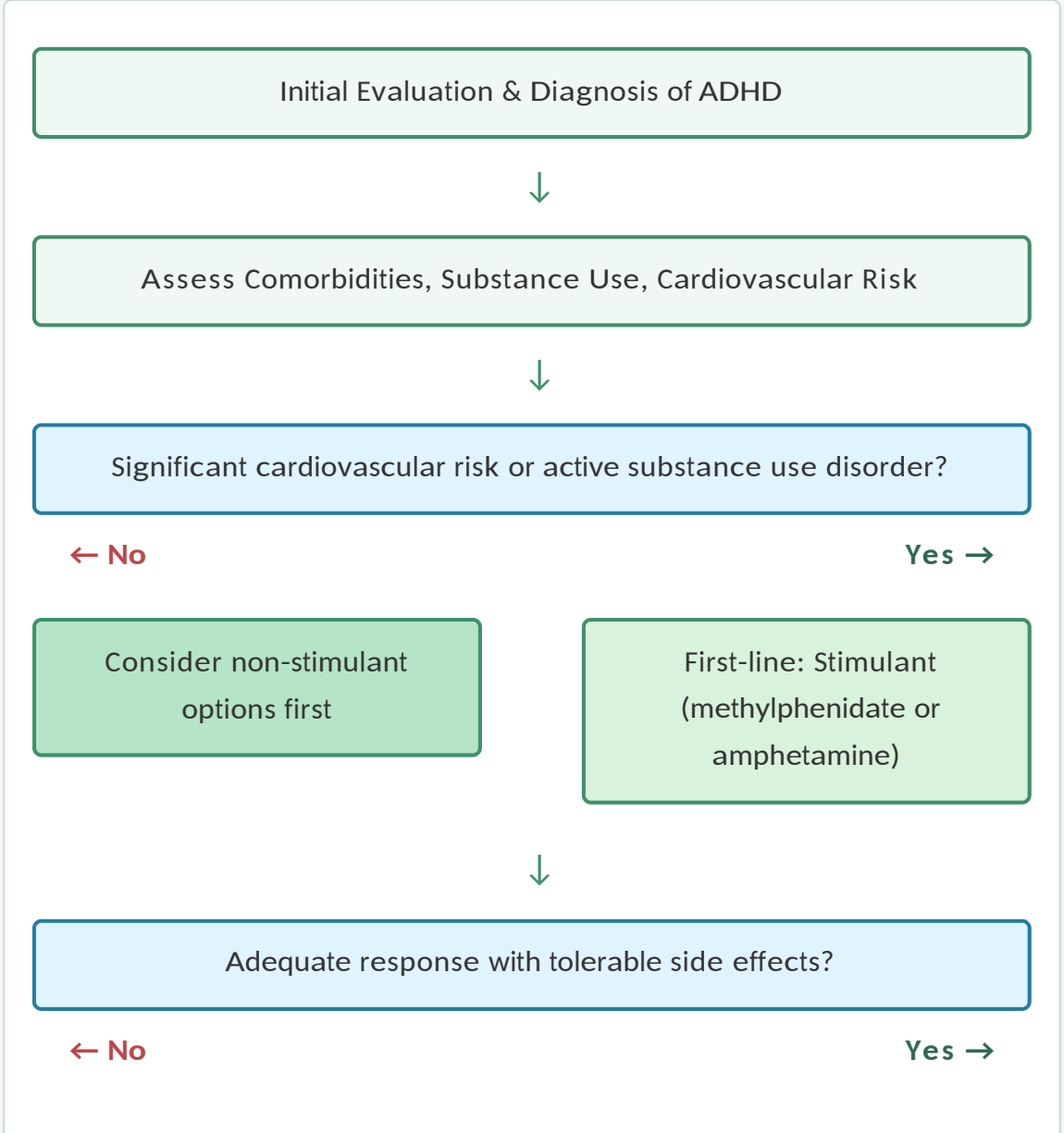
- Baseline: Weight, BMI, waist circumference, BP, fasting glucose, lipid panel
- Weight: Monthly for 3 months, then quarterly
- Metabolic parameters: At 3 months, then annually
- AIMS for EPS: Every 6 months

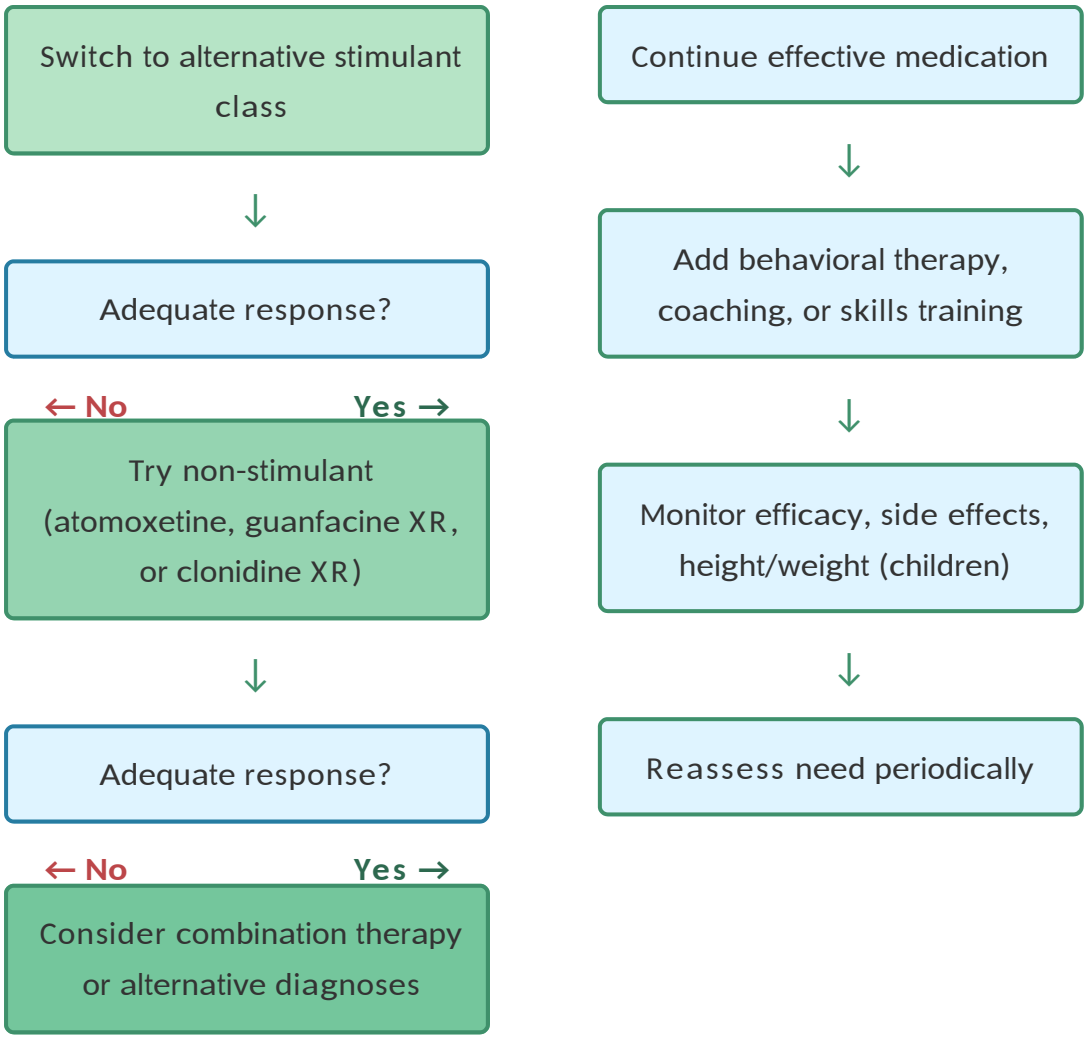
Warning: Combining clomipramine with SSRIs can increase risk of serotonin syndrome. Abrupt discontinuation of OCD medications can

lead to high relapse rates and withdrawal symptoms. Taper very slowly when discontinuing.

Clinical Pearl: *OCD typically requires higher SSRI doses than depression and longer trial duration (10-12 weeks). Combining medication with ERP produces better outcomes than either treatment alone. Poor insight OCD may respond better to antipsychotic augmentation.*

🧩 ADHD Treatment Algorithm





First-Line Treatment Options

Stimulants:

Methylphenidate-based:

- Methylphenidate IR, SR, ER
- Methylphenidate OROS (Concerta)
- Dexmethylphenidate IR, XR

Amphetamine-based:

- Mixed amphetamine salts IR, XR
- Lisdexamfetamine
- Dextroamphetamine IR, SR

Second-Line Treatment Options

Non-stimulants:

- Atomoxetine
- Guanfacine ER
- Clonidine ER

Third-Line/Combination Treatment Options

Combination therapy:

- Stimulant + guanfacine ER
- Stimulant + atomoxetine

Other options:

- Bupropion
- Viloxazine
- Modafinil (off-label)

Medication Dosing Guidelines

Medication	Starting Dose	Titration	Typical Effective Dose	Maximum Dose
Methylphenidate IR	5-10 mg BID-TID	↑ 5-10 mg weekly	20-60 mg/day	60 mg/day (children) 100 mg/day (adults)
Methylphenidate ER (Concerta)	18 mg QAM	↑ 18 mg weekly	36-54 mg/day	72 mg/day
Mixed amphetamine salts XR	5-10 mg QAM	↑ 5-10 mg weekly	15-30 mg/day	30 mg/day (children) 60 mg/day (adults)

Lisdexamfetamine	30 mg QAM	↑ 10-20 mg weekly	50-70 mg/day	70 mg/day
Atomoxetine	0.5 mg/kg/day	↑ after 3 days to 1.2 mg/kg/day	1.2-1.4 mg/kg/day	1.4 mg/kg/day or 100 mg/day
Guanfacine ER	1 mg QD	↑ 1 mg weekly	2-4 mg/day	4 mg/day (children) 7 mg/day (adults)
Clonidine ER	0.1 mg QHS	↑ 0.1 mg weekly	0.2-0.4 mg/day	0.4 mg/day

Monitoring Requirements

Stimulants:

- Baseline: BP, HR, height, weight
- Follow-up: BP, HR at each visit
- Height/weight: Every 3-6 months in children/adolescents
- Consider ECG if cardiac risk factors

Atomoxetine:

- Baseline: BP, HR, LFTs if liver concerns
- Follow-up: BP, HR at each visit
- Monitor for suicidal ideation, especially early in treatment

Guanfacine/Clonidine ER:

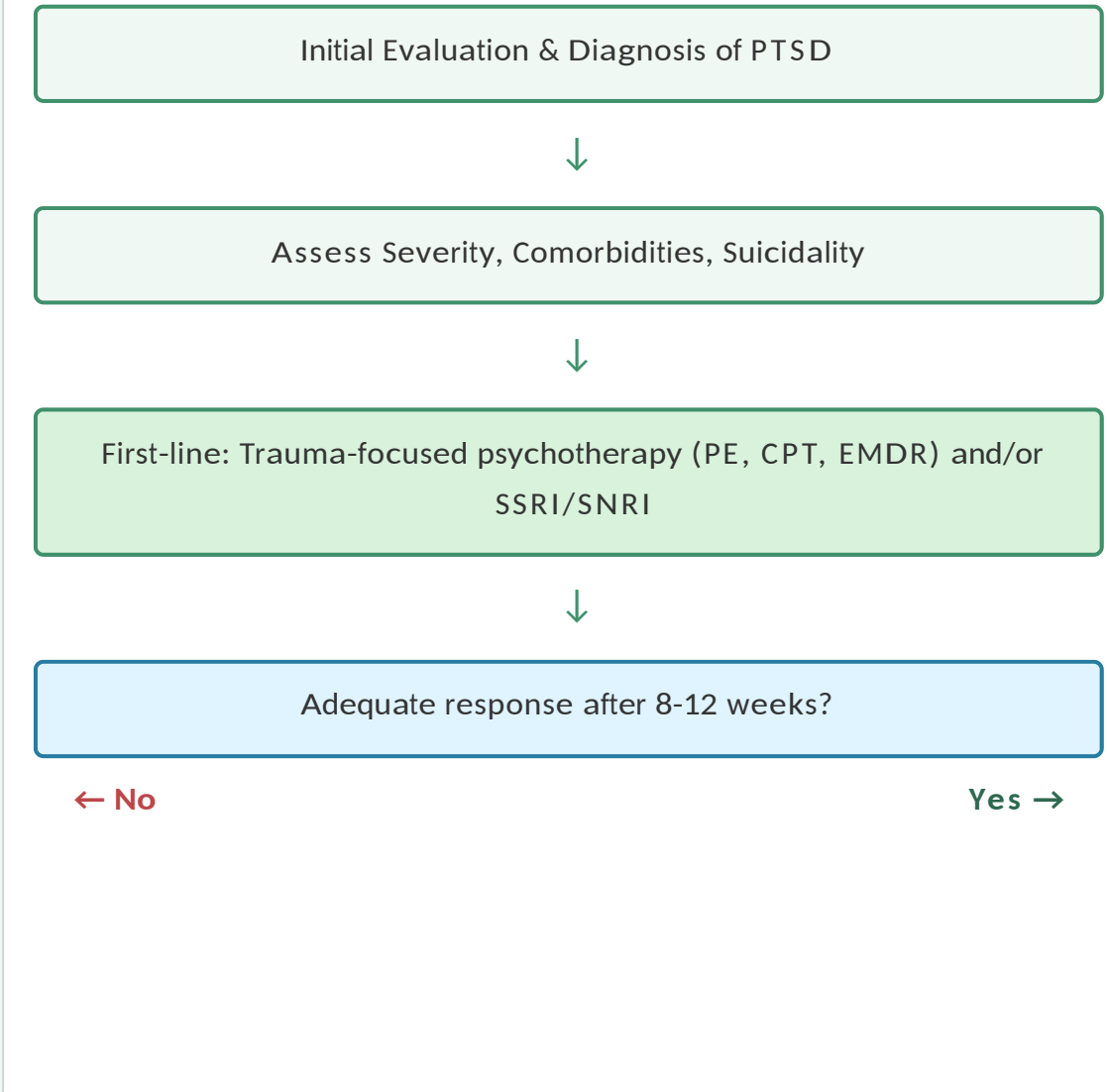
- Baseline: BP, HR, ECG
- Follow-up: BP, HR at each visit
- Monitor for sedation, dizziness, hypotension

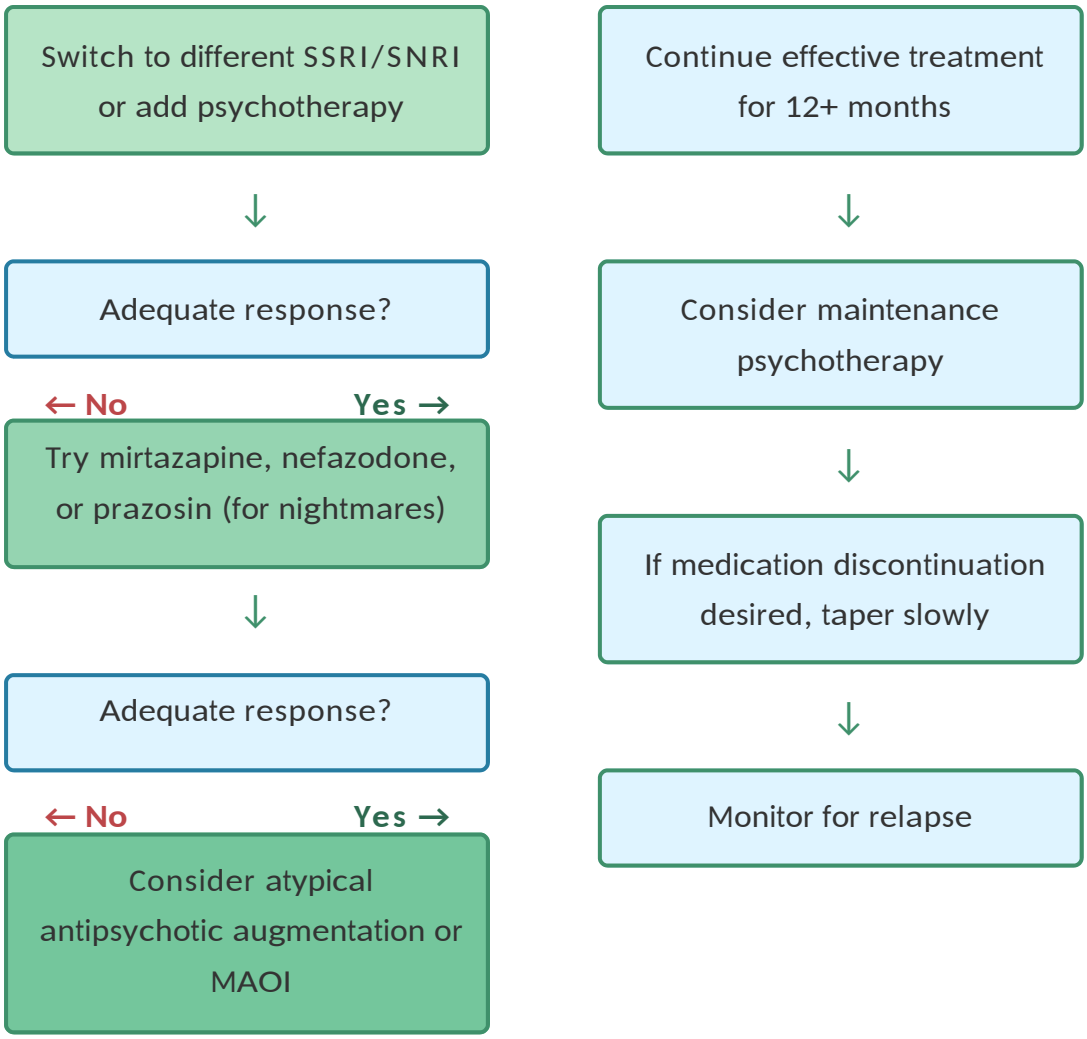
Warning: Stimulants are controlled substances with potential for misuse. Avoid in patients with severe cardiovascular disease, uncontrolled

hypertension, hyperthyroidism, or glaucoma. Stimulants may exacerbate tics, anxiety, or psychosis in vulnerable individuals.

Clinical Pearl: *About 70% of patients respond to the first stimulant trial. If one class of stimulant is ineffective or poorly tolerated, there is still a good chance of response to the other class. Combining medication with behavioral interventions typically produces better outcomes than medication alone.*

🧠 Post-Traumatic Stress Disorder (PTSD) Treatment Algorithm





First-Line Treatment Options

Trauma-focused psychotherapy:

- Prolonged Exposure (PE)
- Cognitive Processing Therapy (CPT)
- Eye Movement Desensitization and Reprocessing (EMDR)

Medications:

- SSRIs: Sertraline, Paroxetine (FDA-approved for PTSD)
- Other SSRIs: Fluoxetine, Escitalopram
- SNRIs: Venlafaxine

Second-Line Treatment Options

Alternative SSRI/SNRI not tried in first-line

Other antidepressants:

- Mirtazapine
- Nefazodone

For nightmares/sleep disturbance:

- Prazosin

Third-Line/Augmentation Strategies

Antipsychotic augmentation:

- Risperidone
- Quetiapine
- Olanzapine
- Aripiprazole

Other options:

- Mood stabilizers (lamotrigine, topiramate)
- Trazodone (for sleep)

Treatment-Resistant PTSD Options

MAOIs:

- Phenelzine

Other options:

- Ketamine/Esketamine (investigational)
- MDMA-assisted psychotherapy (investigational)
- Stellate ganglion block
- Transcranial magnetic stimulation (TMS)

Medication Dosing Guidelines

Medication	Starting Dose	Therapeutic Dose Range	Maximum Dose
Sertraline	25-50 mg/day	50-200 mg/day	200 mg/day
Paroxetine	10-20 mg/day	20-60 mg/day	60 mg/day
Fluoxetine	10-20 mg/day	20-60 mg/day	80 mg/day
Venlafaxine XR	37.5-75 mg/day	150-225 mg/day	375 mg/day
Mirtazapine	15 mg QHS	30-45 mg/day	45 mg/day
Prazosin	1 mg QHS	3-15 mg QHS	20 mg/day
Quetiapine (augmentation)	25-50 mg QHS	50-300 mg/day	300 mg/day
Risperidone (augmentation)	0.5 mg BID	1-3 mg/day	6 mg/day

Monitoring Requirements

SSRIs/SNRIs:

- Assess for response and side effects at 2, 4, 8, and 12 weeks
- Monitor for activation, suicidality (especially in young adults)
- Check BP with SNRIs, especially venlafaxine

Prazosin:

- Monitor BP, especially with first dose (risk of first-dose hypotension)
- Start at low dose and titrate slowly

Antipsychotics:

- Baseline: Weight, BMI, waist circumference, BP, fasting glucose, lipid panel

- Weight: Monthly for 3 months, then quarterly
- Metabolic parameters: At 3 months, then annually
- AIMS for EPS: Every 6 months

Warning: Benzodiazepines are generally not recommended for PTSD as they may interfere with fear extinction and trauma processing. They may worsen outcomes in the long term and carry risks of dependence and withdrawal.

Clinical Pearl: *Trauma-focused psychotherapies have the strongest evidence base for PTSD treatment. Combining medication with psychotherapy may be more effective than either alone, especially for complex or severe PTSD. Prazosin is particularly effective for trauma-related nightmares but less so for daytime symptoms.*

General Clinical Pearls for Psychiatric Treatment:

- *Start low, go slow with medication dosing, especially in elderly, medically complex patients, or those sensitive to side effects*
- *Adequate trial duration is essential before concluding treatment failure (4-6 weeks for most conditions, 10-12 weeks for OCD)*
- *Combining pharmacotherapy with appropriate psychotherapy typically produces better outcomes than either treatment alone*
- *Consider patient preferences, prior treatment response, side effect profiles, and comorbidities when selecting treatments*
- *Monitor for suicidality with all psychotropic medications, especially during initiation and dose changes*
- *Treatment adherence is critical; address barriers and consider long-acting formulations when appropriate*
- *Taper medications slowly when discontinuing to minimize withdrawal symptoms and relapse risk*

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